**Background**: Multivessel and LM lesions, CTO are the indications of CABG. But currently, it is possible to do PTCA in patients with coronary ischemia, even after CABG
**Methods**: 3 years data was analysed in post CABG patients. Details of CABG, current disease and CAG were noted. PTCA was done with DES or BMS. Patients were followed up on OPD basis
**Results**: There were 24 post CABG patients who underwent attempted PTCA. Mean time of presentation after CABG was 8.6 years. Mean age was 56.63 years. 13 (54.16%) were male, 11(45.88%) were female. DM, HTN, dyslipidemia were present in 14(54.33%), 17(70.83%), 16(66.66%) respectively. Avg LVEF was 40.68%.

Presentation at the time of CABG was CSA, STEMI, NSTEMI, USA in 3(12.5%), 8 (33.33%), 7(29.16%), 6(25%) respectively and presentation at the time of PTCA was 12(50%), 2(8.33%), 4(16.66%), 6(25%) respectively

During CABG, 24(100%) had LIMA to LAD graft. SVG graft was used for RCA, LCX, RCA and LCX in 8(20.83%), 5(12.5%), 10(54.33%) respectively. 1 (8.33%) had RIMA to RCA graft.

During CAG, total and subtotal occlusion was present in 6(33.33%) and 5(27.77%) patients in LAD, 5(27.77%) and 4(22.22%) patients in RCA, 4(22.22%) and 2(11.11%) patients in LCX respectively. 6 (25%) had lesion in SVG graft.

In 20 (83.33%) patients, total 26 lesions in native vessels were attempted. 2(7.69%) could not be opened because of CTO. 24 were stented, had 9(34.61%) in LAD, 9(34.61%) in RCA and 6(25%) in LCX. Total 23(88.46%) DES and 3(11.54%) BMS were used.

4(16.66%) underwent attempted PTCA to SVG graft. 3(75%) underwent successful PTCA, all with BMS. During procedure, one had graft perforation which was sealed with covered stent

All patients are following regularly in OPD. Mean follow up is 15.6 months. 5(23.80%) lost follow up. 6(28.57%) developed chest pain who underwent stress thallium scan and all were negative. 3(14.28%) presented with ACS (2 USA,1 NSTMI), only 1 had instent thrombosis.
**Conclusion**: Post CABG PTCA can be attempted in native vessel and graft and has high success rate as in our institute

## Can rotablation atherectomy bypass the bypass surgery in 'drug eluting stent' era?

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**Background**: The patients with heavily calcified lesions, especially in LAD or LM are referred to the surgeons. When patients were unwilling for CABG, Rotablation atherectomy (RA) used to be popular for mechanical debulking in bare-metal stent era but later it became less popular as it was technically demanding and outcomes following PTCA were not promising. This study was done to evaluate our institutional experience with RA and followed by DES implantation in heavily calcified coronary lesions.
**Methods**: From August, 2012 to July, 2014 we had 18 cases of heavily calcified de novo lesions that underwent RA followed by DES implantation. The database at base line and all follow-up visits were analyzed.
**Results**: A total of 18 patients underwent RA for heavily calcified coronary lesions followed by DES implantation during the study period. Of them 60% were diabetics. Multivessel disease was seen in 6 patients. The lesions that had RA were –LAD (13), LCx (3) and RCA (2). Of them 30% were either balloon-non-crossable or non-dilatable (1.25 mm balloon). Procedural success was 17/18 (94.4 %). There were no procedure related MACE at 30 days. At mean follow-up of 5.5 ± 1.35 months, 1 developed CRF and 1 needed elective CABG.
**Conclusion**: RA followed by DES was safe with promising acute and short term results in patients with heavily calcified coronary lesions and bypass surgery could be avoided in almost all of them.

## Single center experience with bioresorbable vascular scaffolds in 'on-label' and 'off- label' indications in PTCA

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**Background**: Since its introduction in 2012, Bioresorbable Vascular Scaffolds (BVS) had shown promising results when used in specified coronary lesions. The experience in 'Off-label' indications is limited.
**Methods**: We studied the technical feasibility, immediate and short-term outcome of usage of BVS the 'real-world' cases including off-label indications in our institute over the last 2 years. We used 30 devices in 20 patients during this period. Standard protocols were followed for the choice of hardware and dual antiplatelet agents. The data is analyzed for lesion characteristics, immediate results and 30-day follow-up.
**Results**: Of the 865 patients that had undergone PTCA during the study period, BVS were implanted in 20 patients (4 females). The mean age was 58 ±2.05 years. Of them 60% were diabetics and 65% were smokers. The location of the lesions was LAD (16), RCA (10), LCx/OM (3) or Ramus (1). The size of devices most frequently used included 3x 28 mm (13) 2.5 x28 mm(6) and 3x 18 mm (5).In 2 cases lesions were ostial and in 3 cases two stents with overlapping had to be done due to long segment disease. Multi-lesional PTCA was done in 5 cases. Of the 30 devices, four were used in 1 patient, three in 1, two in 5 and one each in rest of them. Procedural success was obtained in 19/20 (95%) procedures. One patient developed acute thrombosis in BVS on day one and had responded to balloon dilation and tirofiban infusion. There was no MACE at 30 day and 3 month follow-up. One patient at 5 month follow-up developed angina and had angiographic restenosis. Re-PTCA with DES was done. Patient was symptom-free at follow-up 3 months later.
**Conclusions**: In this real-world experience in a single center, with implantation of 30 BVS, the immediate results and short-term outcomes were very promising. Off-label use had been equally rewarding in our study.

## Unprotected left main coronary artery stenting: A single unit experience

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**Background**: Severe Unprotected LMCA disease, either isolated or associated with other stenoses, is usually treated by CABG